TABLE 1—New Seropositive Cases of HIV Infection in Finland

Year	Helsinki		The whole country	
	Number of new positive HIV cases	Number of persons tested	Number of new positive HIV cases	Number of persons tested
1985	35	3,720	42	6,911
1986	46	7,676	69	24,704
1987	43	17,771	63	95,564

infected heterosexuals about 25 per cent.

In all cases, the diagnosis of HIV infection in Finland is based on antibody detection by enzyme immunoassay, which is confirmed by Western blot assay.

All HIV infections in Finland must be reported to the National Board of Health. The HIV testing is free of charge and done on voluntary basis. The test is obtainable in all health centers, and there are no limitations related to the domicile of an individual to achieve the test. In addition, voluntary testing is offered in Helsinki to prisoners, drug addicts, and patients of venereal disease outpatient clinics. HIV testing is also available in private health service clinics. HIV testing is also available in private health service systems and in outpatient clinics of voluntary organizations, although the number of diagnoses made is small compared to that of communal health care system.

The decreasing trend of observed HIV infections may be due to real reduction of new infections. This could be related to changes in sexual behavior motivated by an expanded program on AIDS information and health education. On the other hand, the information and health education campaigns and the testing policy may have uncovered risk groups in the early phase of this epidemic. The indications for testing as well as the availability of tests and other practical arrangements have not changed in an untoward direction since the onset of testing.

Further follow-up will determine whether the decrease of diagnosed cases reflects the efficacy of preventive means in Finland.

A. Pönkä, MD
J. Tikkanen, MD
O. Haikala, MD
J. Suni, MD
Helsinki City Health Department, 00510 Helsinki, Finland; and National Board of Health

Methodological Difficulties in Dying

The pioneering study by Newman and Browner[1] on the epidemiology of death supports some concerns that our medical ethics teaching unit has had for some years. Despite the strength of a "right to die" movement with the American public, some patients have a great deal of difficulty in dying. While the usual barrier is continuation of life-sustaining medical treatment, in some cases the difficulty is terminological. We have documented two aspects of death that illustrate this point:

1. Permanence of Death—Headline writers in both popular and scientific journals now routinely dispute the old assumption that once dead, always dead. Examples from our collection include:

- "Dead boy lives, thanks to parents' persistence"[2]
- "Youth declared dead for 2nd time in week"[3]
- "Prevention of recurrent sudden death"[4]
- "New hope for sudden death survivors"[5]
- "New therapy for hypertension, heart failure, and sudden death"[6]

2. Choice of Death—We cite the following case reports to illustrate the intriguing concept that whether a body is alive or dead is somehow elective:

Case A: In a case personally known to one of the authors (PJR), the body of a patient, supported by ventilator and without brain function, was declared dead in State X which had a brain-death statute. The body was legally resurrected when the family transported the body, with respirator, across the state line into State Y which then had no such statute in force.

Case B: Wire services recently reported the discovery of the badly decomposed body of a man last seen alive by neighbors 8 years previously. The family had kept the body in bed, and the children were reported to have told friends that their father was "very sick." The county sheriff told reporters, "We are currently investigating the religious aspects of this. Let's just say they have abnormal beliefs in the power of healing."[7]

Our findings, combined with the critical analysis of Newman and Browner, suggest that nothing is certain but taxes.

Howard Brody, MD, PhD
Tom Tomlinson, PhD
Paul J. Reitemeier, MA
Medical Humanities Program, Michigan State University, East Lansing, MI 48824

REFERENCES

1. Newman TB, Browner WS: The epidemiology of life and death: a critical commentary. (satire) Am J Public Health 1988; 78:161–162.
2. Meyers MJ: Dead boy lives, thanks to parents' persistence. Lansing State Journal, February 13, 1983; p 1D.
3. Youth declared dead for 2nd time in week (AP). Washington Post, October 4, 1978.
4. Rapaport E: Prevention of recurrent sudden death. N Engl J Med 1982; 306:1359–1360.
5. Lehmann MH: New hope for sudden death survivors. Michigan Med, February 1987; p 68.
6. New therapy for hypertension, heart failure, and sudden death. Symposium, Cornell University Medical College, Dearborn, MI, April 7, 1982.
7. Dad's body kept home by family for 8 years (AP and UPI). Detroit Free Press, February 2, 1988; p 9A.

Results of Screening Adopted Korean Children for HBsAg

Hepatitis B virus (HBV) transmission among household contacts following the introduction of adopted Asian children has now been well-documented.[1,2] The Centers for Disease Control has recommended that families adopting orphans from countries where HBV is endemic have the child screened for hepatitis B surface antigen (HBsAg).[3] Such screening, however, is not required by law.

We have recently conducted a prospective study testing for HBsAg among South Korean children awaiting adoption. Screening began in January 1985, and continued through July 1986 on all children cared for by Holt Children's Services, Seoul, South Korea, and assigned to a single United States adoption agency. Children were tested for HBsAg 7–14 days prior to their arrival into the United States. All testing was done at a single laboratory in Seoul, using a radioimmunoassay (Ausria II, Abbott Laboratories, North